JACKSON COUNTY

COMMUNITY DIAGNOSIS DOCUMENT

A GUIDE TO HEALTHY COMMUNITIES

1998

Complied by

Upper Cumberland Regional Health Office
Community Development
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Introduction

Mission Statement

The overall mission of the council is to assist the Department of Health by advising the Department regarding the health problems of Jackson County and thus assist the Department in its responsibility to undertake “Community Diagnosis”. The role of the Department of Health is to support the Council by providing the resources needed by the Council to undertake the work, and by facilitating the “Community Diagnosis” process. The following is a proposed objective statement. The mission of the Council is to assist the Department of Health by:

1. Developing a community health assessment which includes health problems and needs identification.
2. Developing goals, objectives, and plans of action to meet these needs along with identifying and securing resources to address these needs.
3. Establishing priorities for all major identified health problems and develop/implement strategies for appropriate interventions.
4. Drafting and presenting to the Department of Health the community health assessment.
5. Promoting and supporting the importance of reducing the health problems to the Department and the community.
6. Maintaining good communications with the Department via periodic reports from the Council through the Regional Health Council Representative and Community Development Staff.

Community Diagnosis

A simple definition used by the North Carolina State Center for Health and Environmental Statistics of a community diagnosis is “a means of examining aggregate health and social statistics, liberally spiced with knowledge of the local situation, in order to determine the health needs of the community.” By using this definition, we acknowledge that significant input from residents of the local area is essential to performing a community diagnosis effectively. Although a great deal of quantified health data can be obtained from the State, the process will only be successful if local citizens are fully involved and are comfortable with the eventual findings. This is why the formation and effective utilization of county health councils are vital in achieving accurate results.

The final outcome of community diagnosis and its products should:

- Provide justification for budget improvement requests submitted to the State Legislature;

- Provide to state-level programs and their regional office personnel information that fosters better planning, promotion, and coordination of prevention and intervention strategies at the local level;

- Serve health planning and advocacy needs at the community level. Here, the community leaders and local health departments provide the leadership to ensure that documented community health problems are addressed.

The end result of the process will be a set of prioritized health goals and proposed interventions to address the needs of the community. The Tennessee Department of Health is committed to assisting communities throughout our state in finding the answers to these questions via the Community Diagnosis process. This document will explain the community diagnosis process and outcomes for Jackson County. We will also provide a historical perspective with details of the council and its formation.

History

"Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy."

The Future of Public Health
Institute of Medicine, 1988

This manual is designed to assist local communities, local and regional health departments, and the state department of health in fulfilling the mission of public health, as defined above. If we, as a society, are to improve the conditions that affect the health of all of us, we must begin in local communities, dealing with local conditions. Health care is a very localized phenomenon. The needs and problems of one community may be very different from other communities, even those in close geographical proximity. Community leaders together with local health departments have a responsibility to play key roles in this effort. They should lead their communities in an examination of local health problems and in the development of plans to overcome those problems.

This mission can be accomplished by implementing the three core functions of public health at all levels of government. They are:

Assessment: The assessment function involves the monitoring and surveillance of local problems, the assessment of needs, and the identification of resources for dealing with them.

Policy Development: Policy development goes hand in hand with leadership which fosters local involvement and a sense of ownership of those policies. It should emphasize local needs and should advocate an equitable distribution of public resources and complementary private activities commensurate with community needs.

Assurance: Assurance means that high quality services, including personal health services, which are needed for the protection to the health of the community are available and accessible to all persons. Each community should receive proper consideration in the allocation of federal, state, and local funds for health. Each community should be informed about how to obtain public health services and/or comply with health requirements.

In summary, community-based health planning is a process which assists local citizens in their respective communities to do the following:

- **Identify the community's health care needs.**
- **Examine the social, economic, and political realities affecting the local delivery of health care.**
- **Determine what the community can realistically achieve in a health care system to meet their needs.**
- **Develop and mobilize an action plan based on analysis for the community.**

The end result of the process should answer three questions for the community:

Where is the community now?
Where does it want to be?
How will it get there?

The Tennessee Department of Health is committed to assisting communities throughout our state in finding the answers to these questions via the Community Diagnosis process. The following is the White County Community Diagnosis Document which details the process the White County community utilized to assess its strengths, weaknesses, and gaps in resources. A very thorough analysis of health statistical data, community surveys, resources, and key leaders' perception of White County's health care status facing the community is presented in document form to be utilized as a baseline document for public relations, grant applications, and as a foundation of the work plan for the future.

Summary

The Jackson County Health Council was established in 1994 by the Upper Cumberland Community Health Agency, currently known as the Upper Cumberland Community Services Agency. This council may consist of various community leaders such as the Mayor, County Executive, Hospital Administrator, School Superintendent, industry representation, health care providers, mental health care providers, Nursing Home representation, local law enforcement, various community agencies, and other community leaders as determined by council members. (Appendix 1) The Department of Health Community Development Staff coordinated with the Jackson County Health Council in January of 1996 in order to facilitate the Community Diagnosis Process. The Health Council's dedication and commitment to the process was evident through their willingness to become one of the state's pilot projects for the Community Diagnosis Process. The Community Diagnosis process seeks to identify community health care problems by analyzing health statistical data, community surveys, and council perceptions. The initial step in the process is to select a county health council. The basic steps of the Community Diagnosis process are as follows:

- **Assemble the initiating group**
- **Select the County Health Council**
- **Present data to the council**
- **Discuss and define health problems**
- **Analyze the Behavioral Risk Factor Survey**
- **Distribute and Analyze the Stakeholders Survey**
- **Score/Rank health problems**
- **Design interventions**
- **Develop funding strategies**
- **Assess development and effectiveness of interventions**

During the course of the Community Diagnosis Process, the Jackson County Health Council established Bylaws (Appendix 2) that reflect the mission and goals of the council illustrating their commitment to their community. The Council typically meets on the first Thursday of each month from 11:30 a. m. to 1:00 p. m. where meetings are open to the public.

County Description

Geographic

- Jackson County, located in the eastern portion of the Upper Cumberland Region, is surrounded by Smith, Putnam, Overton, Clay, and Macon counties.
- Jackson County is located 74 miles east of Nashville, and 122 miles west of Knoxville.
- The county is predominantly rural with access to Interstate 40 and various state highways.
- The average annual temperature is 56, with annual rainfall of 53 inches.

Land Area

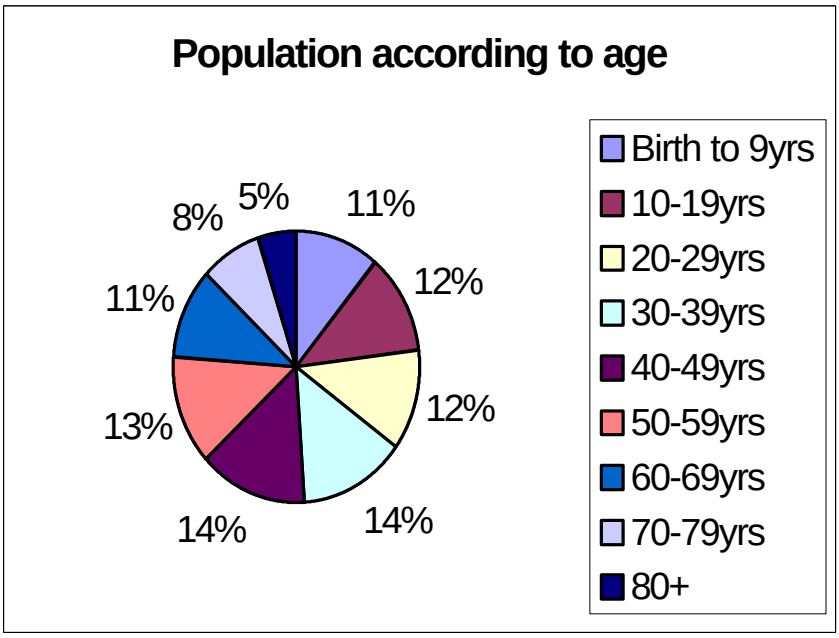
- Jackson County is a farming community consisting of 308.9 square miles.
- Jackson County is located on the Cumberland Plateau, and predominately has rolling hills no higher than 400ft.
- The number one farm crop is tobacco.
- Both the Cumberland and the Roaring River flow through Jackson County.

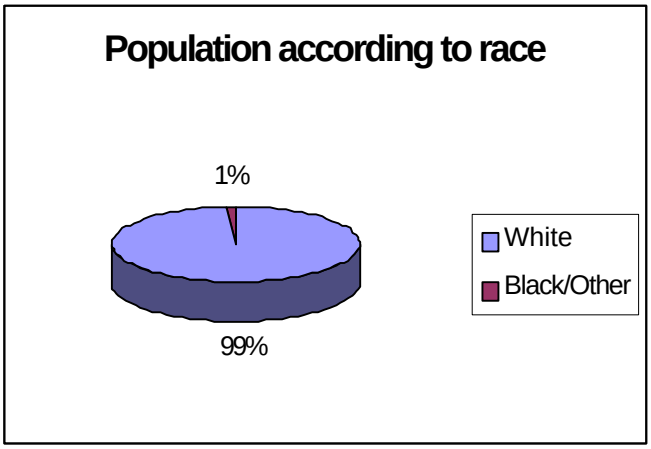
Economic Base

- The county's median Family personal income is $21,834.
- The county's median Household personal income is $18,081.
- Jackson County's per capita personal income is $9,159.
- Corporate industries such as Aeroquip, Crotty-Tennessee, Inc., Memphis Chair, Nielsen & Bainbridge, and Old World Woodcrafters employ approximately 865 people total.
- The 1998 Average Labor-Force total is 4,650, of those, 4,260 are employed and 390are unemployed giving Jackson County an unemployment rate of 8.4%.
- Jackson County's Work Force total is 2,360 with 970 in manufacturing and 1,390 in nonmanufacturing work.
- The average weekly income of 1997 wages were $369.

Demographics

- Jackson County is predominantly rural with 50.7% below the 200% poverty guidelines while 33% are on TennCare.
- Jackson County's public education system has 2 Elementary Schools and 1 Jr High/Sr High School with a total enrollment of approximately 1,016.
- Jackson County's population estimates for 1997 a total of 9,588. The following chart illustrates the percent of the population according to are groups and race.
- The population projections for Jackson County for the year 2000 is 9,183, and the projection for the year 2010 is 8,984.





Medical Community

- Jackson County Hospital, which was a 41 bed facility, is now operating under a temporary licensure extension providing an emergency unit, open at all times. The county government is currently supporting this facility and has staffed it with 24 hour access to an RN, an LPN, and an on-call physician.
- There are 11 medical doctors and 3 dentists located in Jackson County.
- Jackson County's TennCare Dental ratio to TennCare enrollees ranks them 45 in the state for Dental needs. The Dentist to TennCare enrollees ratio is 1:7,755 serving the TennCare population.

References: Tennessee Department of Health, Upper Cumberland Development District

Community Needs Assessment

Primary Data

Jackson County Health Survey

Prior to beginning the Community Diagnosis process, the Jackson County Health Council developed its own survey to determine the community's perception of the priority health problems or needs. The top ten results are as follows.

1	Drug Abuse
2	Teen Pregnancy
3	Preventive Services
4	Violence
5	Clean Water
6	Auto Accidents
7	Chronic Disease
8	Homemaker Services
9	Farm Injuries
10	Emergency Services

Stakeholder

The stakeholder survey will provide a profile of perceived health care needs and problems facing the community and the stakeholders who respond to the survey. Stakeholders are those individuals in a community who have a special interest in a particular issue or action being taken. The stakeholders represented a cross section of the community, i.e., young families, single parents, the elderly, farmers, business leaders, and rural residents, etc. The stakeholders included both users and providers of health services. The survey included questions about the availability, adequacy, accessibility, and level of satisfaction of health care services in the community. The stakeholder survey is not a scientific, random sample of the community. Its purpose is to obtain data from a cross section of the community about the health care services, problems, and needs in the community.

The results of the Stakeholders Survey are as follows:

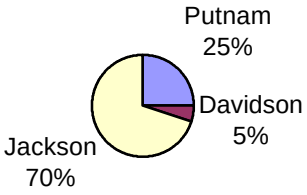
Do you have a personal health care provider?

Yes	95%
No	5%

Is this provider a:

Physician	80.0%
Nurse Practitioner	15.0%
Unrecorded	5.0%

In which county does your personal health care provider practice?



To which hospital does your personal health care provider refer patients?

Cumberland River South	60.0%	Unrecorded	5.0%
Cookeville General	30.0%		
Baptist	5.0%		

Do you have health insurance?

Yes	100%

Primary Health Providers

Satisfied	Not Satisfied
Accessibility	Obstetrical Services
Reputation	Support Staff Services
Convenience	
Facility/Equipment	
Laboratory	
Quality of Care	
Cost compared to others	

Availability of Health Care Services

Available/Adequate	Not Adequate to Meet the Demands
Primary Physician Care	Specialized Physician Care
Acute Illness Hospital Care	Eye Care
Nursing Home/Residential Care	Chiropractic Services
In-home Health Care	Health Promotion/Wellness
Emergency Room Care	Child Abuse/Neglect Services
Ambulance/EMS Services	Maternal/Prenatal Health Services
Dental Health Services	Alcohol and Drug Treatment
Child Health Services	Elderly Meals on Wheels
Family Planning Services	Mental Health Services
Pharmacy Needs	

Behavioral Risk Factor Survey

The Behavioral Risk Factor Survey (BRFS) is a random telephone survey, coordinated through the Centers for Disease Control, which collects information from adults on health behaviors and knowledge related to leading causes of death in each of the states. About half of all deaths occurring annually are now attributed to modifiable behavioral risks. In addition to determining what types of health risks are most prevalent in the population, the BRFS data will be very useful in determining what types of interventions are most needed for other health problems such as excess deaths from a particular chronic disease. A modified version of the standard BRFS was developed specifically for the "Community Diagnosis" process. In addition to the questions on the standard BRFS survey, a series of health issues are listed. The respondent is asked if the issue is a "Definite Problem", "Somewhat of a Problem", "Not a Problem", or "Not Sure". The list of the health issues with their frequency of response as a "Definite Problem" is as follows:

Alcohol Abuse	**66%**
Drug Abuse	**65%**
Allergies	**61%**
Arthritis	**60%**
High Blood Pressure	**58%**
Heart Conditions	**52%**
Teen Pregnancy	**49%**
Obesity	**43%**
Stress	**33%**
Unintended Pregnancy	**30%**
Diabetes	**30%**
Lung Cancer	29%
Emphysema	26%
Breast Cancer	25%
Family Violence	24%
Child Abuse Neglect	24%
Asthma	23%
Prostate Cancer	22%
AIDS	19%
STD's	18%
Eye Disease	15%
Colon Cancer	15%
Cervical Cancer	15%
Eating Disorders	12%
Teen Suicide	10%
Adult Suicide	10%

Top Ten Issues Highlighted

Access to Care Issues:

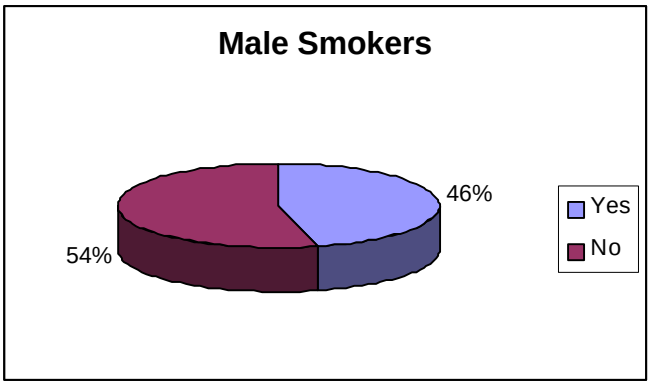
Lack of Financial Resources	**26%**
Access to Dental Care	**24%**
Access to Eye Care	**18%**
Access to Prenatal Care	**15%**
Trans. to Health Care	**13%**
Access to Daycare for Homebound	12%
Toxic Wastes	10%
Access to Nursing Home	10%
Air Pollution	8%
Access to Homemaker Services	7%
Access to Home Health Care	6%
Access to Birth Control	5%
Access to Physician Care	5%

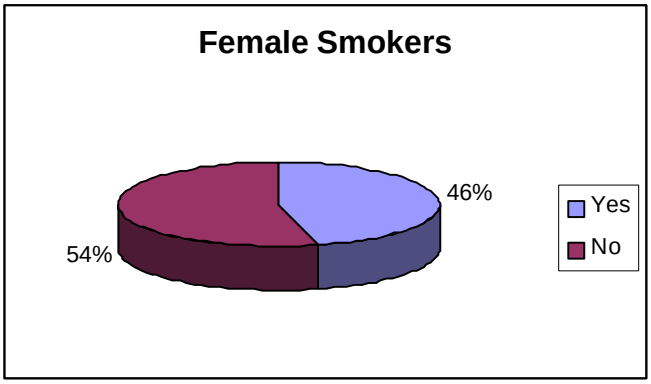
Top Five Issues Highlighted

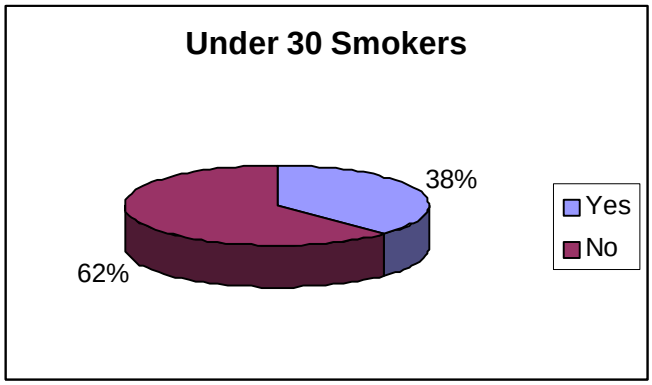
Other issues to consider:

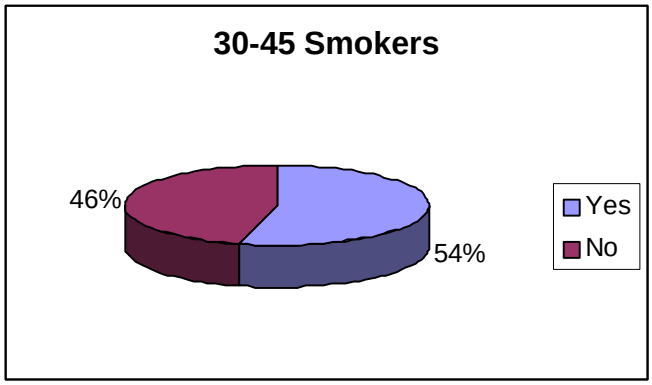
Tobacco Use:

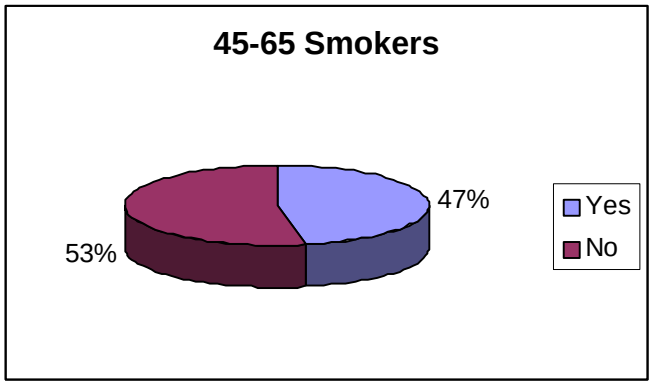
Percent of the population surveyed that considers themselves a smoker according to gender and age:

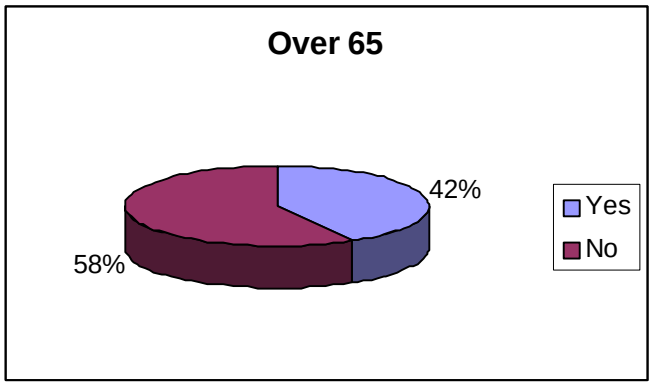





Under 30 Smokers
38%
62%
Yes
No


30-45 Smokers
46%
54%
Yes
No


45-65 Smokers
47%
53%
Yes
No


Over 65
42%
58%
Yes
No

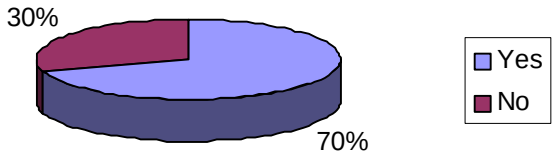
Questions Regarding Mammograms

Percent of the female respondents that have had a mammogram according to age:

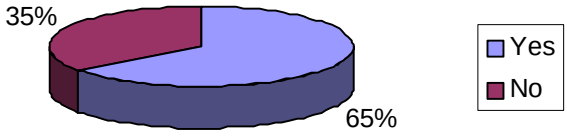
30-35:	**58%**
45-65:	**84%**
Over 65:	**67%**

Has a doctor ever recommended a mammogram?

Ages 30-45



Ages 45-65



Questions regarding sexual behavior:

Due to what the respondent understands about HIV has that changed their sexual behavior?
Ages: Under 30: 69% responded No
30-45: 84% responded No

Sexual intercourse with more than one partner?
Ages: Under 30: 50% responded Yes
30-45: 65% responded Yes

Have you used condoms for protection?
Ages: Under 30: 70% responded Yes
30-45: 63% responded Yes

More careful in selecting sexual partners?
Ages: Under 30: 67% responded Yes
30-45: 60% responded Yes

If you had a sexually active teenager, would you encourage use of a condom?
Ages: Under 30: 88% responded Yes
30-45: 91% responded Yes
45-65: 84% responded Yes
Over 65: 60% responded Yes

The BRFS reveals the community's perception of health-related issues and concerns. Initially the BRFS included Allergies in the survey, after its revision Allergies were excluded in the other counties. Tobacco Use was included in the revision and therefore Jackson County's BRFS does not reflect the overall community perception of Tobacco Use. In most all of the Upper Cumberland counties that were administered the revised BRFS, **Tobacco Use** was the **Number One** community concern. Even though, Jackson County's BRFS does not reveal this directly, the council surmised based on smoking questions asked that Tobacco Use would be in the top 10 problems if it had been addressed as such. Therefore, based on the questions asked pertaining to smoking habits and the fact that Lung Cancer was ranked in the top 10 problems, the council inserted Tobacco Use as a top priority.

According to the BRFS, Alcohol and Drug Abuse were ranked as top concerns of the community with teen pregnancy and unintended pregnancies ranking close to them. The council's perception is that very often these four problems are interrelated and can lead to a combination of health related problems. Across the region, alcohol/drug issues, and teenage pregnancies are in the top 10 concerns within each community.

Arthritis and High Blood Pressure are also top concerns of the community. Across the region, high blood pressure has continuously ranked as a top concern for most counties. Obesity, Heart Conditions, and Stress are also ranked as top concerns of the community. It is the council's perception that these conditions can be interrelated and one condition may be the result of the other. Therefore, the council perceived these conditions as a total Wellness issue to be addressed as a whole.

Access to Care Issues:

In analyzing the access to care issues as perceived by the community, the lack of financial resources is a definite concern for the respondents. After reviewing poverty data and employment information, the council's concern is that this issue is much broader in scope and correlates to other access to care issues. Within the top areas of concern access to dental care, prenatal care and eye care, are issues that the council has focused on in merging information from other sources. Access to prenatal care is an issue that could be linked with the increasing trend in late or no prenatal care as illustrated previously in the pregnancy and birth data.

Secondary Data

Summary of Data Use

Health Indicator Trends
Jackson County, Tennessee
Using 3-Year Moving Averages
1983-1994 Trend

Pregnancy and Birth Data

Data is based on information from the Office of Vital Records, Tennessee Department of Health. All health indicator trends are formatted into three-year moving averages to reflect a trend over the past ten years. (See Appendix 3 for corresponding graphs)

Health Indicator	County Trend	County Compared to Region	County Compared to State
1. Number births/1,000 females	Increasing	Above	Below
2. Percent births to unwed women	Increasing	Above	Below
3. Number teenage pregnancies	Decreasing	Below	Below
4. Number pregnancies/1,000 females	Increasing	Above	Below
5. Number pregnancies/1,000 females ages 10-14	Increasing	Above	Above
6. Number pregnancies/1,000 females ages 15-17	Decreasing	Below	Below
7. Number pregnancies/1,000 females ages 18-19	Increasing	Above	Below
8.Percent pregnancies to unwed women	Increasing	Above	Below
9. Percent of live births classified as low birth weight	Unstable	Above	Below
10. Percent of live births classified as very low birth weight	Unstable	Above	Above
11. Percent births with 1 or more high risk characteristics	Decreasing	Below	Below

12. Infant deaths/1,000 births	Stable	Below	Below
12. Neonatal deaths/1,000 births	Stable	Below	Below

In analyzing the pregnancy and birth trends, the council focused on the following trends that showed *an increasing* indicator:

- Number of births/1000 females
- Percent births to unwed women
- Number pregnancies/1000 females
- Number pregnancies/1000 females ages 10-14
- Number pregnancies/1000 females ages18-19
- Percent pregnancies to unwed women

Mortality Data

Using information reported by physicians on death certificates, underlying cause of death is coded by staff in Vital Records. The staff uses National Center for Health Statistics rules for assigning codes for underlying cause of death. Tennessee does not capture immediate or multiple cause of death. (See appendix 4 for corresponding graphs)

Health Indicator	County Trend	County Compared to Region	County Compared to State
White male age-adjusted mortality rate/100,000 population	Stable	Above	Above
Other race male age-adjusted mortality rate/100,000 population	Unstable	Below	Below
White female age-adjusted mortality rate/100,000 population	Decreasing	Above	Above
Other race female age-adjusted mortality rate/100,000 population	Unstable	Below	Below
Female breast cancer mortality rate/100,000 women age 40 or more	Increasing	Above	Above
Nonmotor vehicle accident mortality rate	Unstable	Above	Above
Motor vehicle accidental mortality rate	Decreasing	Above	Above
Violent death rates/100,000 population	Unstable	Above	Above

Even though the Health Indicator Trend shows a decrease in the motor vehicle accident mortality rate, the health council found other data from the Department of Health that shows an increase over both the state and the Upper Cumberland in that mortality rate. The findings are as follows:

- Motor vehicle accident mortality rates have shown a dramatic increase since 1989.
- Motor vehicle accident mortality rates are significantly higher than the Upper Cumberland Region's rates.
- Motor vehicle accident mortality rates are above the 1993-1995 state rate. Jackson: 57.6 vs. State: 25.0
- In ages 65 and up, the motor vehicle accident rates increased from 1987 to 1996.

Morbidity Data

Based on the number of incidence (new cases) which occur for a given disease in a specified time frame and the number of prevalence (existing cases) for a disease in a specified time period. (See Appendix 5 for corresponding graphs)

Health Indicator Trend	County Trend	County Compared to Region	County Compared to State
1. Vaccine preventable disease rate/100,000 population	Stable	Below	Below
2. Tuberculosis disease rate/100,000 population	Increasing	Above	Above
3. Chlamydia rate/100,000 population	Increasing	Below	Below
4. Syphilis rate/100,000 population	Stable	Below	Below
5. Gonorrhea rate/100,000 population	Stable	Below	Below

Further 1996 analysis of morbidity data revealed the following:

Chronic Obstructive Pulmonary Disease for those ages 65 and over is above the 94-96 state rate: Jackson County – 371 vs the State – 269.9

Jackson County:
The number of reported AIDS cases for 1998 – 0
The number of reported HIV cases for 1998 – 5
Regional data:
AIDS – 117
HIV – 127
The number of TB cases shows an increasing trend since 1987, but has begun to decline since 1995.

Healthy People 2000 Objectives

In 1991, the Public Health Service of the U.S. Department of Health and Human Services published Healthy People 2000: National Health Promotion and Disease Prevention Objectives. That report was intended to assist both health providers and consumers in addressing measurable targets to be achieved by the year 2000. The data contained in this report addresses health status indicators for births, deaths, selected diseases, and external influences. The following is a comparison of the objectives to Jackson County. The data used for Jackson County is based on 1994-96 three year moving averages.

Healthy People 2000 Compared to Jackson County

Health Status Indicators	Jackson County Rate	Tennessee Rate	Nation's Rate
Death from all causes	649.1	563.1	No Objective
Coronary Heart Disease	173.9	134.8	100
Deaths from Stroke	33.2	34	20
Deaths of Females from Breast Cancer	108.9	22.4	20.6
Deaths from Lung Cancer	58.8	47.5	42
Deaths from Motor Vehicle Accidents	58.9	23.6	16.8
Deaths from Homicide	7.8	12.1	7.2
Deaths from Suicide	14.4	12.6	10.5
Infant Deaths	8.4	9.6	7.0
Percent of Births to Adolescent Mothers	4.5	6.6	none
Low Birthweight	9.5	8.7	5.0
Late Prenatal Care	23.7	19.9	10.0
Incidence of Aids	*	14.1	-----
Incidence of Tuberculosis	32.2	11.6	3.5

* Three-year cumulative total cases are less than 5.

The indicators that are in bold are Jackson County's rate's that are above the state's objectives according to Tennessee's Healthy People 2000.

List of Data Used by Source

TN Department of Health Office of Vital Records
TN Department of Health Picture of the Present, 1997
TN Department of Health, Health Access
TN Department of Economic and Community Development
Upper Cumberland Development District
Healthy People 2000

Health Issues and Priorities

Community Process

In summary, the Health Indicator Trends that have exhibited an increasing trend over the past 10 years are:

- **Number of births/1,000 females**
- **Percent births to unwed women**
- **Number of pregnancies/1,000 females**
- **Number of pregnancies/1,000 females ages 10-14**
- **Number of pregnancies/1,000 females ages 18-19**
- **Percent pregnancies to unwed women**
- **Female breast cancer mortality rate/100,000 women age 40 or more**
- **Tuberculosis disease rate/100,000 population**
- **Chlamydia disease rate/100,000 population**

In analyzing these trends, the council's overall awareness of these problems increased dramatically. One of their overall concerns with respect to pregnancy and birth data is the increase in teenage pregnancies and pregnancies to unwed mothers. Along with these concerns, is the perception that many teens are sexually active thus the increase in STD's and teen pregnancies. With regards to communicable disease control, within the total Upper Cumberland Region, STD rates have exhibited an increasing trend since 1994 including Chlamydia, Gonorrhea, and Syphilis. Total regional cases of AIDS and HIV are increasing each year. Tuberculosis and sexually transmitted diseases including HIV/AIDS continue to pose significant health threats in Tennessee. Local health departments provide testing, counseling, treatment and contact tracing to control the spread of these diseases. Efforts to promote childhood immunizations are another extremely important responsibility. The Department of Health provides immunizations, tracks immunization rates through an annual survey of 24-month old children, and provides outreach to encourage parents to immunize their children against diphtheria, pertussis, tetanus, polio, measles, mumps, and rubella.

After a thorough analysis of all data sets, Behavioral Risk Factor Survey, and Stakeholders Survey, the council established priorities among a multitude of problems. The following health priorities and their related recommendations are listed below. In order to ensure that all health problems are addressed in the same way, the council utilized a process which is objective, reasonable, and easy to use. The method that was used sets priorities based on the size and seriousness of the problem in conjunction with the knowledge about the effectiveness of potentially available interventions. All issues were identified through the Council's discussion, review of the data, and related "Data Analysis" in the previous section. The health issues are listed in prioritized order with the first being the highest priority.

Prioritized Health Issues

Council Ranking	BRFS	Health Indicator Trends (Secondary Data)
(1) Alcohol & Drug Abuse	Alcohol Abuse (1) Drug Abuse (2)	A) Chronic Liver Disease and Cirrhosis peeked in 1986-1990 in ages 25-44, has since declined and remain below the region and the state. B) Reference "Health Status of Tennesseans."
(2) Motor Vehicle Deaths	Not Addressed	A) Motor Vehicle Deaths have increased since 1991. Rates are above the state and the region. B) Upper Cumberland ranked 4th in state in alcohol-related crashed (9.1%) leveled off.
(3) High Blood Pressure	(5)	Cerebrovascular Disease mortality rate has declined since 1986-88 in ages 25-44 and is below the region and the state. In ages 45-64, the rates are still low and are below the state and the region. In ages 65+, the rates have increased since 1988 and remain steady, but are above the region and state.
(4) Heart Conditions	(6)	Diseases of the Heart mortality rate has shown a drastic increase in ages 25-44 since 1990 and is well above the region and the state. In ages 45-64, the rates have increased since 1988 and remain well above the region and the state. In ages 65+, the rates have remained steady, but are above the region and the state.
(5) Obesity	(8)	See Heart Conditions and High Blood Pressure
(6) Tobacco Use	Lung Cancer (12)	Lung Cancer incidence rates are below the region and the state's rates.
(7) Diabetes Diabetes Cont.	(11)	According to Report of Diabetes for the year 1996-97, the County Health Departments in the region diagnosed a total of 213 patients with some form of Diabetes. The statewide patient count in the Health Department for the year July1996-June1997 is 5035
(8) Cancer	Breast Cancer (14) Colon Cancer (22) Cervical Cancer (23)	Female Breast Cancer Mortality Rates have declined drastically from 1985-87 to 1991-93. Since that time, the rates have steadily increased with the rate for 1994-96 being above both the state and the region. In ages 15-24 Malignant Neoplasm Mortality Rate showed a drastic increase from 1991-93 to 1992-94. This rate is well above the region and the state. In ages 25-44, the rates increased from 1989-91 to 1992-94 and have leveled of remaining slightly below the region and the state. In ages 45-64, rates have remained steady below the region and the state. In ages 65+, the rates declined from 1989-91 and have leveled off remaining below the region and

Cancer cont.		the state.
(9) Teen Pregnancy	(7)	Teen Pregnancy Rates have declined since 1991-93 and are below the state and the region.
(10) Unintended Pregnancy	(10)	Percentage of pregnancies to unwed mothers ages 10-44 has increased steadily since 1988-90. The percentage remained above the region from 1990-92 to 1993-95 but is below the state's percent.

Jackson County Priorities

To ensure the accuracy of the council's ranking, the prioritization table provided a means of comparison of all top issues addressed. Further secondary data was analyzed including leading causes of death including chronic liver disease and cirrhosis, cerebrovascular disease, heart disease, and malignant neoplasms. The analysis revealed that cerebrovascular disease mortality rates, heart disease mortality rates, and malignant neoplasm mortality rates have shown increasing trends over the past several years. Motor Vehicular death rates were further analyzed and revealed an increasing trend with rates above the state and the region. The council's perception based on the data and input from law enforcement was that many of the motor vehicular deaths are alcohol and drug related causing community concern regarding alcohol and drug abuse issues.

Because diabetes was ranked in the top issues of concern, a further analysis of actual diabetes patients for Jackson County revealed a relatively small number diagnosed for the county based on Department of Health information. Further Female Breast Cancer Mortality rates revealed that rates have shown a dramatic increase since 1991 and the rates are significantly higher than the region and state rates. Teen Pregnancy rates have declined and are below the state and the region, however, percentage of pregnancies to unwed mothers has increased steadily with the percent remaining above the region and below the state.

After an extremely thorough analysis of data, surveys, and council perception, alcohol and drug abuse issues became the priority focus for the Jackson County Health Council. Because of the communities perception of alcohol and drugs revealed through surveys and the high motor vehicular death rate, the two issues were merged together to focus on teen alcohol and drug abuse.

The following issues are listed in priority order by the Jackson County Health Council:

1	Alcohol & Drug Abuse
2	Motor Vehicle Deaths
3	High Blood Pressure
4	Heart Conditions
5	Obesity
6	Tobacco Use
7	Diabetes
8	Cancer
9	Teen Pregnancy
10	Unintended Pregnancy

Future Planning

Through the Community Diagnosis process, it was determined that the top issue of concern was the Teen Alcohol and Drug Problem in Jackson County. The future plans of the Jackson County Health Council are to establish an Alcohol and Drug Task Force to include members from the Health Council (Appendix 6) that are willing to invest their time and energy to develop an action plan that will address the alcohol and drug issues facing Jackson County.

The Jackson County Health Council hopes to achieve it's mission by enhancing education and increasing awareness of children and their parents to the dangers of alcohol and drug use by utilizing positive role models and information/data through educational school programs.

Appendices

Appendix 1

Council Makeup

Jackson County Health Council

Dolores Angelini: Chairperson,
Community volunteer
688 Lambert Hollow Lane
Granville, TN 38564

Karen Cook
Jackson County Brd of Education
2387 South Grundy Quarles
Gainesboro, TN 38562

Jay Cassetty: President
Citizens Bank
P.O. Box 515
Gainesboro, TN 38562

Dr. George Dudney: Physician
2895 Free State Road
Gainesboro, TN 38562

Diane Herald
Department of Human Services
P.O. Box 295
Gainesboro, TN 38562

Cassandra Jenkins
Phoenix Healthcare
633 Chestnut Street, Suite 600
Chattanooga, TN 37450

Kevin King: Safe and Drug-Free
Coordinator
3104 Fisk Road
Cookeville, TN 38501

N. Garry Lee: School Supt.
2387 South Grundy Quarles
Gainesboro, TN 38562

Becky Hawks: TN Dept. of Health
Cordell Hull Building, 4th Floor
425 5th Ave. North
Nashville, TN 37247

Deidre Scott: Lab Director
Cumberland River Hospital South
620 Hospital Drive
Gainesboro, TN 38562

Joyce Draper Director
Jackson County Health Dept.
716 Lakeview Drive
Gainesboro, TN 38562

Pat Farley,R.N. School Nurse
1146 Old Highway 52
Celina, TN 38551

Carolyn Fox: Ag Extension
P.O. Box 335
Gainesboro, TN 38562

Rita Jenkins: Community Volunteer
345 Camp Branch Lane
Whitleyville, TN 38588

Dr. Jack Johnson: Physician
P.O. Box 125
Crestview Avenue
Gainesboro, TN 38562

Cindy Kernea: School Counselor
161 Schelley Knob Lane
Gainesboro, TN 38562

Jackson County Sentinel
Attention: Susan Robbins
204 South Union Street
Gainesboro, TN 38562

Helen Dennis: R.N.
442 South Grundy Quarles Hwy.
Gainesboro, TN 38562

Terry Montgomery: School Counselor
P.O. Box 158
Gainesboro, TN 38562

Paula Raines: Marketing
Cumberland River Hospital
620 Hospital Drive
Gainesboro, TN 38562

Nancy Richardson: Nursing Supervisor
Jackson County Health Dept.
P.O. Box 312
Gainesboro, TN 38562

Julie Veness
March of Dimes
1200 Mountain Crk. Rd., Suite 130
Chattanooga, TN 37405

Angie Beaty
American Cancer Society
508 State Street
Cookeville, TN 38501

Patsy Yates
P.O. Drawer 151
Granville, TN 38564

Virgnia Frizzell
509 County Wood Lane
Gainesboro, TN 38562

Beverly Madewell
Stephens Center/Healthy Start
403 University Street
Livingston, TN 38570

Judy & Vernon Ragland
1752 Fort Blount Ferry Road
Gainesboro, TN 38562

Danny and Bette Thomas
2890 Gladdice Hwy
Whitleyville, TN 38588

Ralph Broyles
Jackson County Farm Bureau
PO Box 317
Gainesboro, TN 38562

Sherry Lindberg
County Executive's Office
101 E. Hull Avenue
Gainesboro, TN 38562

Joan Sisco: School Teacher
2238 Gladdice Hwy
Gainesboro, TN 38562

Dutch Warren
Town of Gainesboro
511 Warren Drive
Gainesboro, TN 38562

Ellen Martin
1245 Skaggs Branch Road
Whitleyville, TN 38588

Willie Mai Brewington
5191 Jennings Creek Highway
Whitleyville, TN 38588

Herb Leftwich
Jackson County High School
190 Blue Devil Lane
Gainesboro, TN 38562

Garry and Karen Jones
P.O. Box 733
Gainesboro, TN 38562

Teresa Mayberry
2325 Shepardsville Road
Bloomington Springs, TN 38545

Helen Draper
205 Crescent Drive
Gainesboro, TN 38562

Marilyn Dibble
1436 Gladdice Highway
Whitleyville, TN 38588

Carolyn Isbell
The Stephens Center
403 University Street
Livingston, TN 38570

Sandy Allen
Quality Home Health
P.O. Box 697
Jamestown, TN 38556

Bill Christopher
UCHRA
3111 Enterprise Drive
Cookeville, TN 38506

Erskine Peoples Blue Care
801 Pine Street
Chattanooga, TN 37402-2555

Kathy Shea: Prevention Coordinator
Valley Ridge Mental Health Center
P.O. Box 297
Lafayette, TN 37083

Pat Chaffin
Dept. of Human Services
P.O. Box 295
Gainesboro, TN 38562

Dale Stapp: Library
P.O. Box 647
Gainesboro, TN 38562

Tom Lyles: Minister
108 North Cedar
Cookeville, TN 38501

Paul Sharp
506 W. Gibson Ave.
Gainesboro, TN 38562

Kimberly Freeland
Regional Health Office

Buffalo Valley, Inc.
P.O. Box 117
501 Park Avenue South
Hohenwald, TN 38462

Deborah Cassetty
Jackson County Health Department

VaLinda Phillips
Jackson County Health Department

Rev. Stephen Lee
P.O. Box 206
Gainesboro, TN 38562

Wayne Mahaney: Sheriff
268 Flynns Creek Road
Gainesboro, TN 38562

Margie Quarles
P.O. Box 65
Gainesboro, TN 38562

Carlene Davis
506 W. Gipson Ave.
Gainesboro, TN 38562

Florence Brodrick
Community Person
271 Old Fox Hill Lane
Gainesboro, TN 38562

Charlie Hix
County Executive
Jackson County Courthouse
Gainesboro, TN 38562

Appendix 2

Bylaws for Jackson County Health Council

ARTICLE I. NAME

The name of this council shall be JACKSON COUNTY HEALTH COUNCIL (hereafter referred to as “COUNCIL”) and will exist within the geographic boundaries of Jackson County, Tennessee. The council shall exist as a non-incorporated, not-for-profit, voluntary membership community service organization.

ARTICLE II. PURPOSE AND GOALS

The overall mission of the council is to assist the Department of Health by advising the Department regarding the health problems of Jackson County and thus assist the Department in its responsibility to undertake “Community Diagnosis”. The role of the Department of Health is to support the Council by providing the resources needed by the Council to undertake the work, and by facilitating the “Community Diagnosis” process. The following is a proposed objective statement. The mission of the Council is to assist the Department of Health by:

1. Developing a community health assessment which includes health problems and needs identification.
2. Developing goals, objectives, and plans of action to meet these needs along with identifying and securing resources to address these needs.
3. Establishing priorities for all major identified health problems and develop/implement strategies for appropriate interventions.
4. Drafting and presenting to the Department of Health the community health assessment.
5. Promoting and supporting the importance of reducing the health problems to the Department and the community.
6. Maintaining good communications with the Department via periodic reports from the Council through the Regional Health Council Representative and Community Development Staff.

ARTICLE III. AUTHORITY

1. The Council shall exist as an advisory and support body to Tennessee Department of Health solely for the purpose stated herein and shall not be vested with any legal authority described to Tennessee Department of Health, the State of Tennessee or any of its political subdivisions. Recommendations of the Council will not be binding upon Tennessee Department of Health and the Council is not granted authority to act on behalf of The Department of Health without specific prior written authorization.

2. Any monies or properties generated by the Council or for the Council will be deposited and managed on behalf of the Council by a not for profit agency or organization selected and approved by the Council.
3. The Council shall provide Tennessee Department of Health a strict accounting of all financial transactions arising from Council activities. The financial records and accounts of the Council will be made available to Tennessee Department of Health and/or its official auditors for examination at any time upon reasonable request.

ARTICLE IV. MEMBERS

Attendance at the Health Council meetings shall be voluntary. Attendees will be considered voting members after attendance at two (2) consecutive meetings. Membership will continue until the Council is notified or the attendee has more than three (3) unexcused absences in a one-year period, January to January. The Council shall consist of an adequate number of voting members as to be effectively representative of all segments of the community. Leaders in the areas of health care, finance, business, industry, civic organizations, social welfare organizations, advocacy groups, and government may be invited to serve. The Council shall also invite the membership of health care consumer representatives from diverse socioeconomic backgrounds. Residency in Jackson County is desirable but not a pre-requisite for membership.

ARTICLE V. OFFICERS

Section 1: Officers

The officers of the Council shall consist of the Chairman, Vice-Chairman, Secretary/Treasurer.

Section 2: Chairman

The Chairman will be elected by majority vote of the Council from nominees among its members. The Chairman will preside over all meetings of the Council and will set the agenda for each meeting.

Section 3: Vice-Chairman

The Vice-Chairman will be selected by majority vote of the Council from nominees among its members. The Vice-Chairman will preside in the absence of the Chairman and assume duties assigned by the Chairman.

Section 4: Secretary/Treasurer

The Secretary/Treasurer will be selected by majority vote of the Council from nominees among its members. The Secretary/Treasurer shall keep account of all money arising from Council activities. No less than annually, or upon request, the Secretary/Treasurer shall issue a financial report to the membership. Additionally the Secretary/Treasurer will record the business conducted at meetings of the Council in the form of minutes, will issue notice of all meetings and perform such duties as assigned by the Council.

Section 5: Term of Office

Officers shall be elected at the meeting in or following January of each year for a term of one year/maximum three years.

ARTICLE VI. MEETINGS

Section 1: Regular Meetings

The Council will conduct regularly scheduled meetings, at intervals of no less than once every two (2) months, to be held at a time and place specified by the Council Chairman.

Section 2: Special Meetings

The Council Chairman may call a special meeting, as deemed appropriate, upon five days written notice to the membership.

Section 3: Approval of Motions

Acceptance of motions consists of approval from the majority of the members present.

ARTICLE VII. COMMITTEES

The Council may establish such standing or special committees as deemed appropriate for the conduct of its business. Committee membership will be assigned by the Chairman and may consist of both Council members or other concerned individuals who are not members of the Council

ARTICLE VIII. APPROVAL AND AMENDMENTS

These Bylaws will become effective upon approval by a majority vote of the membership of the Council. Thereafter, these Bylaws may be amended or repealed at any regular or special meeting called for the purpose by a majority vote of the voting members present, provided that the proposed additions, deletions or changes have been submitted in writing to all Council members not less than thirty days prior to the meeting at which formal action on such amendments are sought.

ADOPTED BY THE JACKSON COUNTY HEALTH COUNCIL

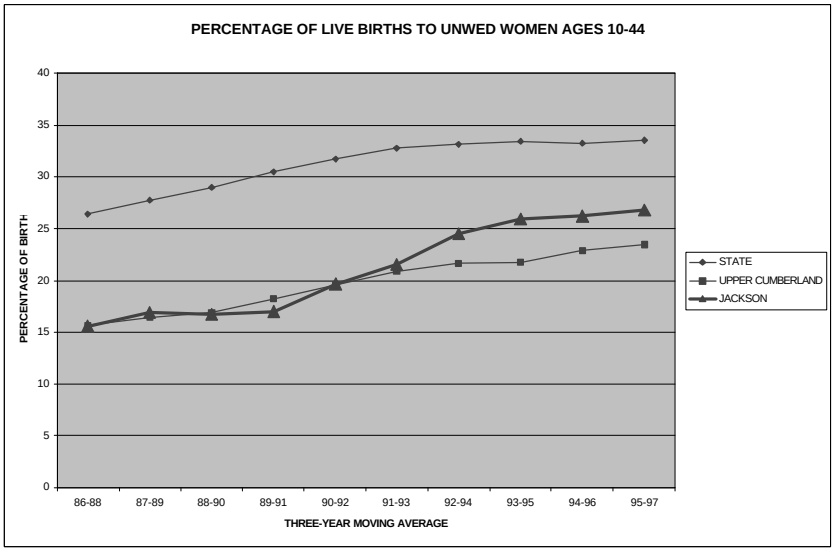
This the _____ Day of _____, 1998.

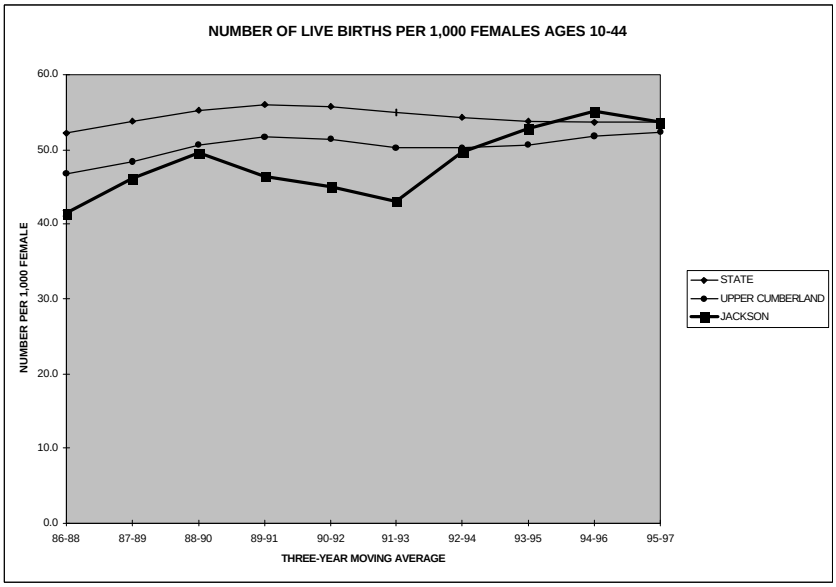
_____ _____
Chairman Date

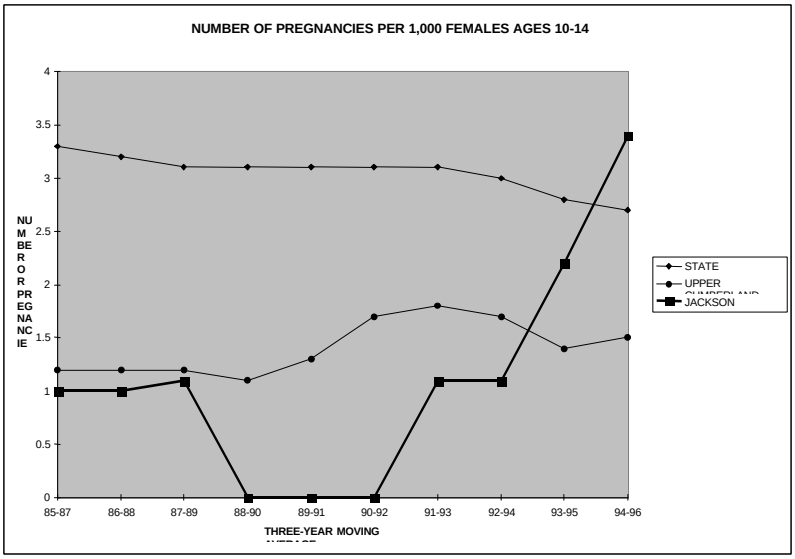
_____ _____
Vice-Chairman Date

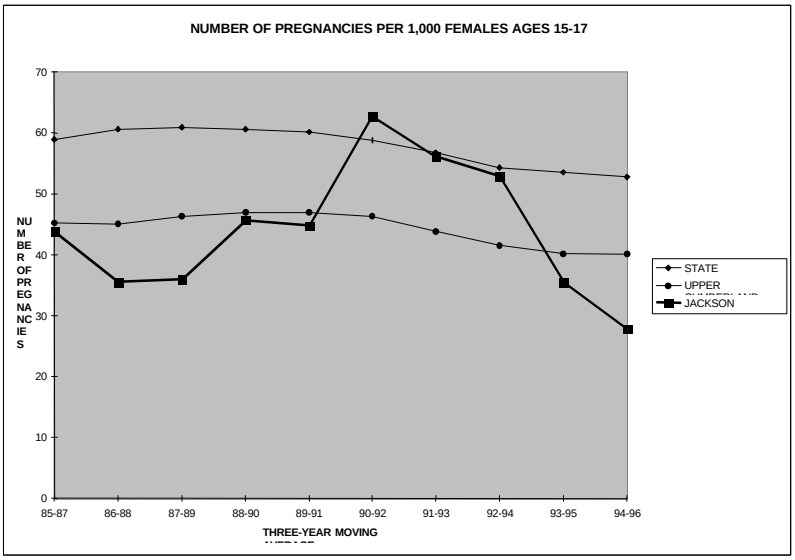
Appendix 3

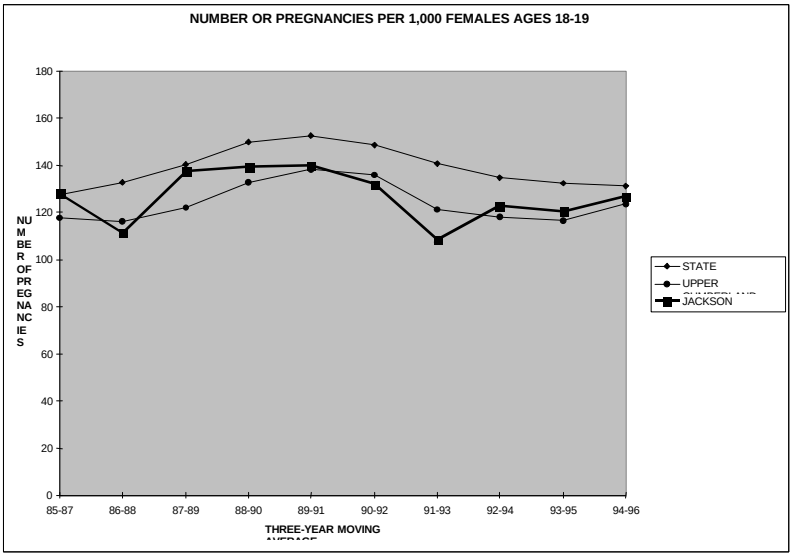
Pregnancy and Birth Data

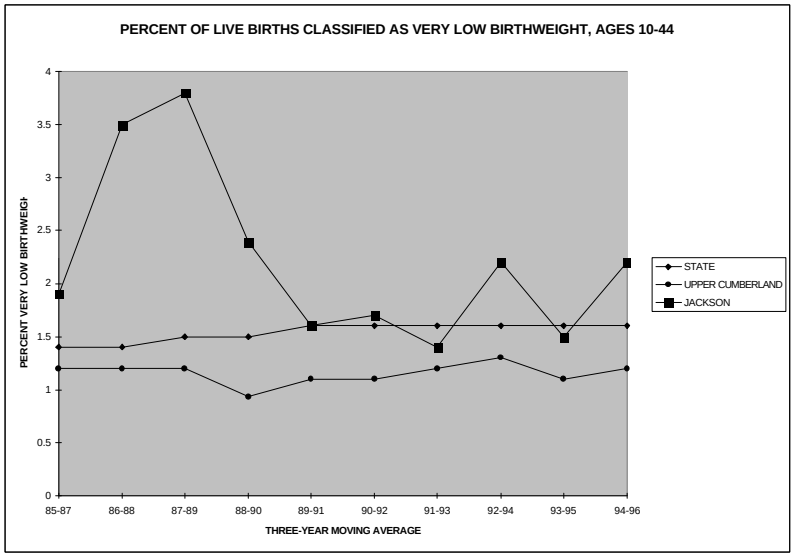


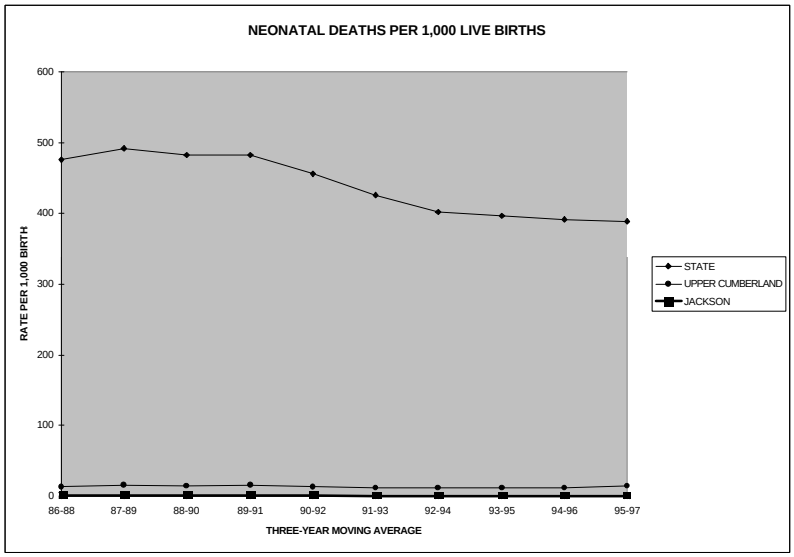


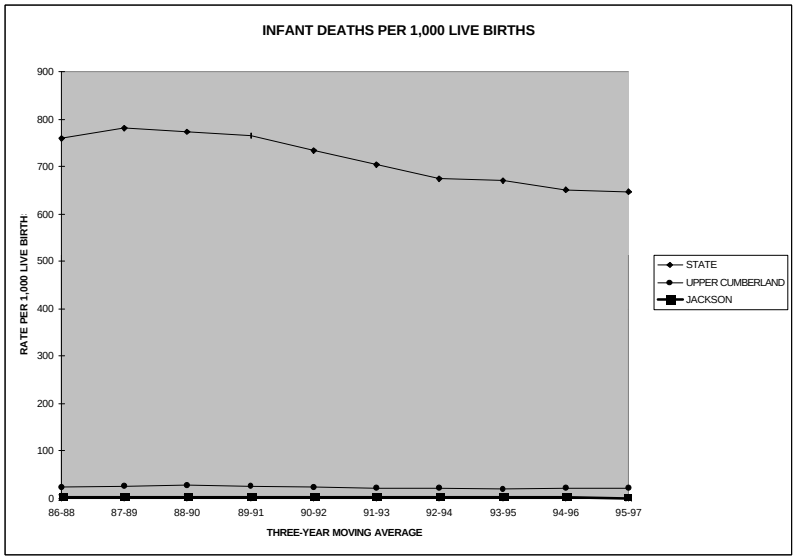

NUMBER OF PREGNANCIES PER 1,000 FEMALES AGES 10-14
NUMBER OR PREGNANCIE
4
3.5
3
2.5
2
1.5
1
0.5
0
85-87
86-88
87-89
88-90
89-91
90-92
91-93
92-94
93-95
94-96
THREE-YEAR MOVING
STATE
UPPER
JACKSON

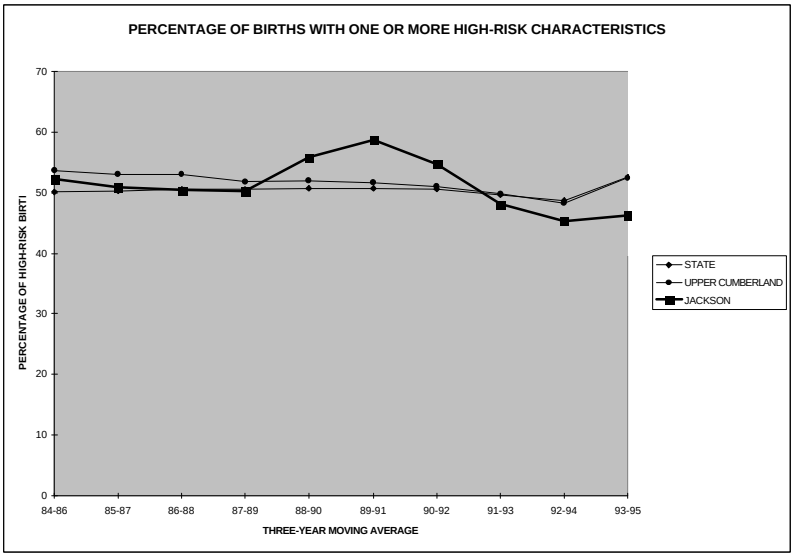

NUMBER OF PREGNANCIES PER 1,000 FEMALES AGES 15-17
NUMBER OF PREGNANCIES
70
60
50
40
30
20
10
0
85-87
86-88
87-89
88-90
89-91
90-92
91-93
92-94
93-95
94-96
THREE-YEAR MOVING
STATE
UPPER
JACKSON

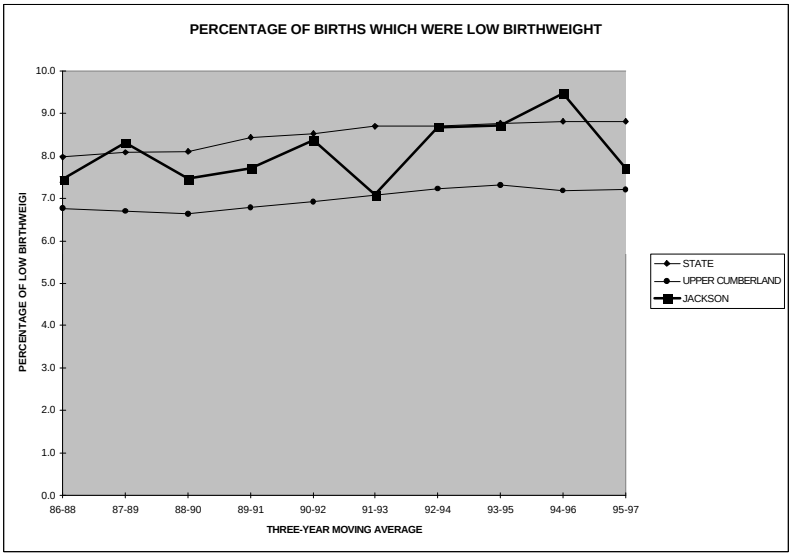

NUMBER OR PREGNANCIES PER 1,000 FEMALES AGES 18-19
NUMBER OF PREGNANCIES
180
160
140
120
100
80
60
40
20
0
85-87
86-88
87-89
88-90
89-91
90-92
91-93
92-94
93-95
94-96
THREE-YEAR MOVING
STATE
UPPER
JACKSON

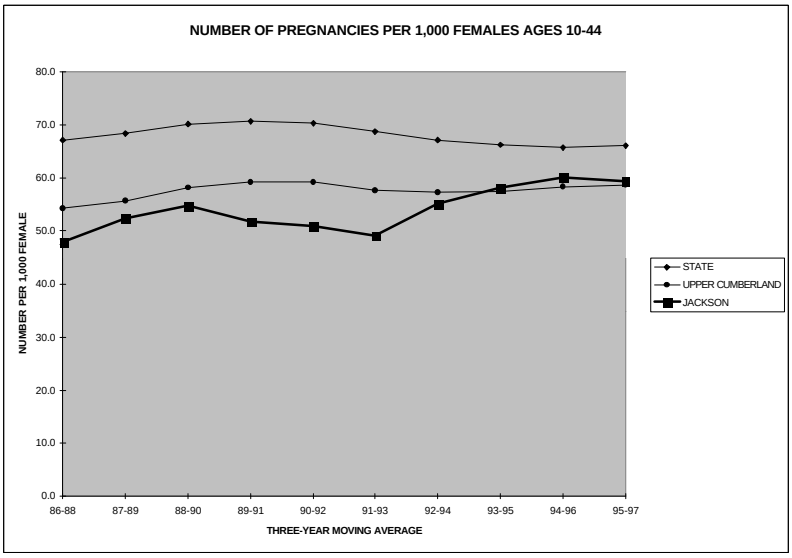

PERCENT OF LIVE BIRTHS CLASSIFIED AS VERY LOW BIRTHWEIGHT, AGES 10-44
PERCENT VERY LOW BIRTHWEIGHT
4
3.5
3
2.5
2
1.5
1
0.5
0
85-87
86-88
87-89
88-90
89-91
90-92
91-93
92-94
93-95
94-96
THREE-YEAR MOVING AVERAGE
STATE
UPPER CUMBERLAND
JACKSON

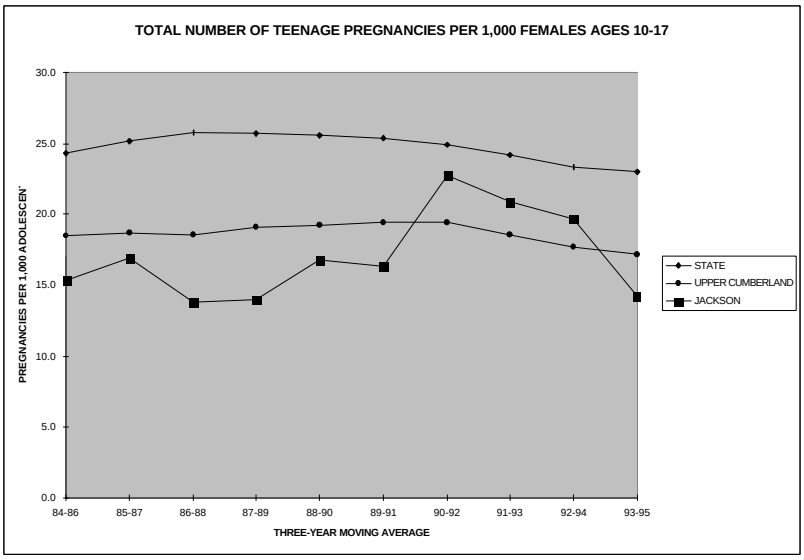

NEONATAL DEATHS PER 1,000 LIVE BIRTHS
RATE PER 1,000 BIRTH
600
500
400
300
200
100
0
86-88
87-89
88-90
89-91
90-92
91-93
92-94
93-95
94-96
95-97
THREE-YEAR MOVING AVERAGE
STATE
UPPER CUMBERLAND
JACKSON


INFANT DEATHS PER 1,000 LIVE BIRTHS
RATE PER 1,000 LIVE BIRTH
900
800
700
600
500
400
300
200
100
0
86-88
87-89
88-90
89-91
90-92
91-93
92-94
93-95
94-96
95-97
THREE-YEAR MOVING AVERAGE
STATE
UPPER CUMBERLAND
JACKSON


PERCENTAGE OF BIRTHS WITH ONE OR MORE HIGH-RISK CHARACTERISTICS
PERCENTAGE OF HIGH-RISK BIRTI
70
60
50
40
30
20
10
0
84-86
85-87
86-88
87-89
88-90
89-91
90-92
91-93
92-94
93-95
THREE-YEAR MOVING AVERAGE
STATE
UPPER CUMBERLAND
JACKSON

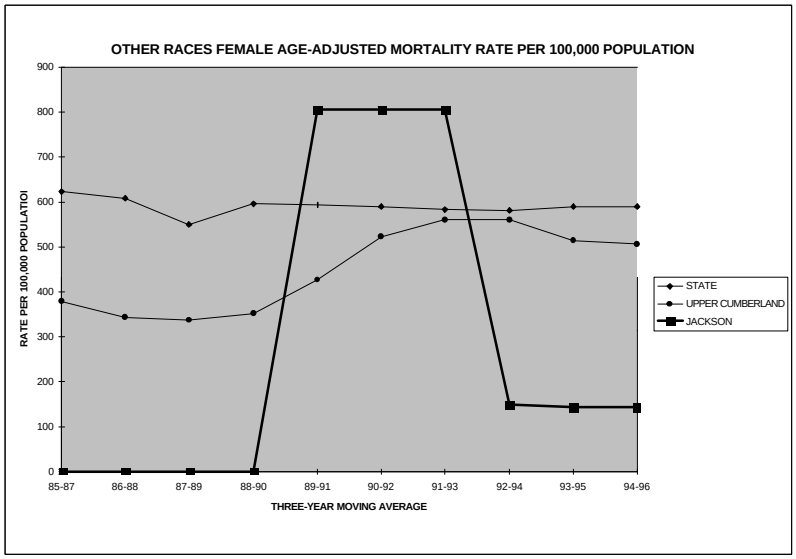

PERCENTAGE OF BIRTHS WHICH WERE LOW BIRTHWEIGHT
PERCENTAGE OF LOW BIRTHWEIGI
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
86-88
87-89
88-90
89-91
90-92
91-93
92-94
93-95
94-96
95-97
THREE-YEAR MOVING AVERAGE
STATE
UPPER CUMBERLAND
JACKSON

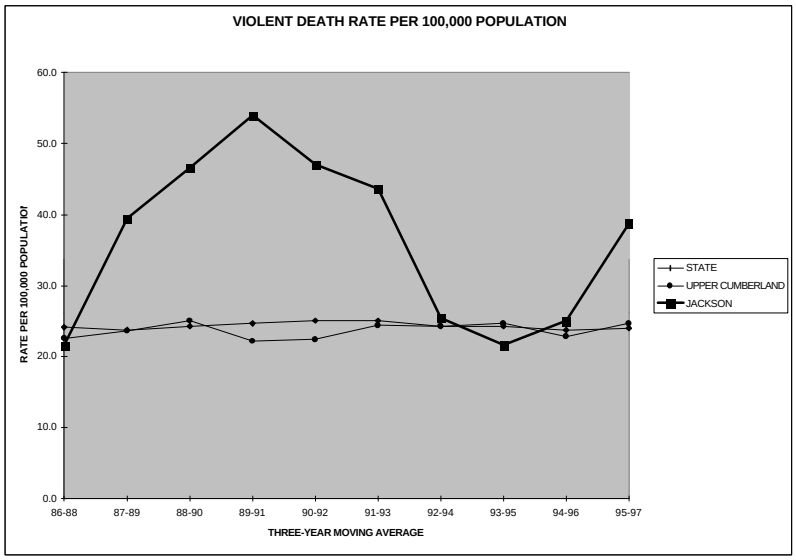

NUMBER OF PREGNANCIES PER 1,000 FEMALES AGES 10-44
NUMBER PER 1,000 FEMALE
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
86-88
87-89
88-90
89-91
90-92
91-93
92-94
93-95
94-96
95-97
THREE-YEAR MOVING AVERAGE
STATE
UPPER CUMBERLAND
JACKSON

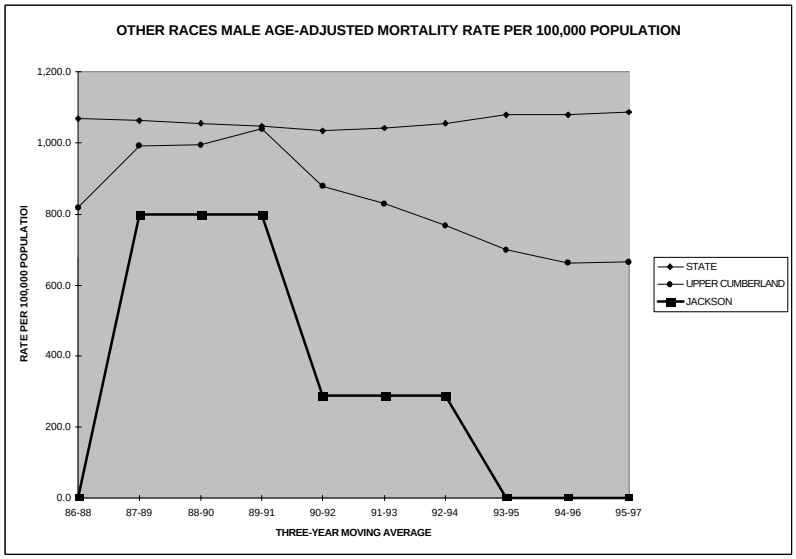

TOTAL NUMBER OF TEENAGE PREGNANCIES PER 1,000 FEMALES AGES 10-17
30.0
25.0
20.0
15.0
10.0
5.0
0.0
PREGNANCIES PER 1,000 ADOLESCEN
84-86
85-87
86-88
87-89
88-90
89-91
90-92
91-93
92-94
93-95
THREE-YEAR MOVING AVERAGE
STATE
UPPER CUMBERLAND
JACKSON

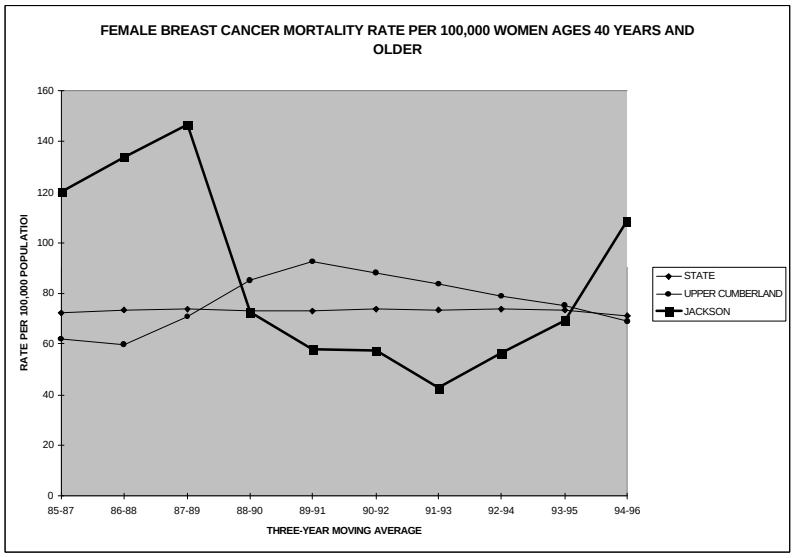
Appendix 4

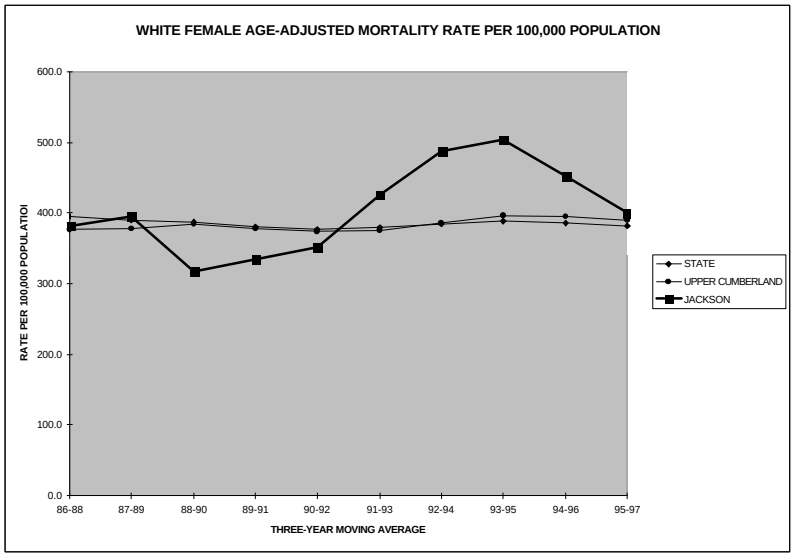
Mortality Data

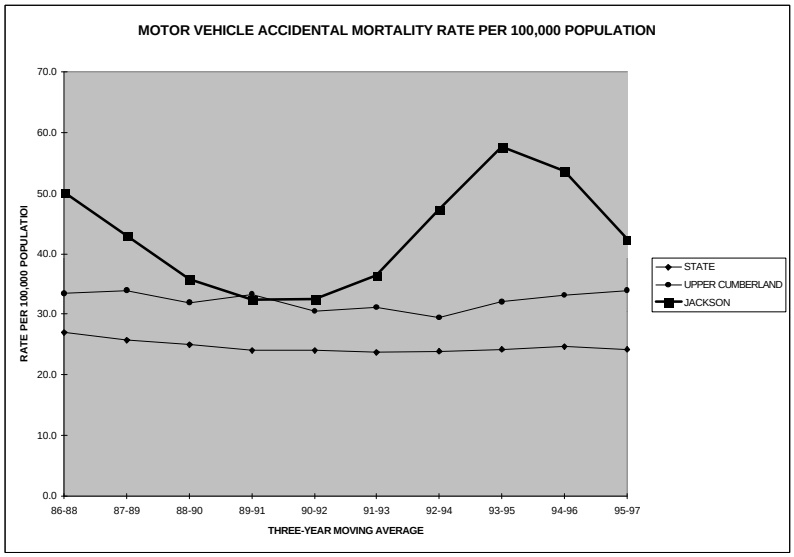


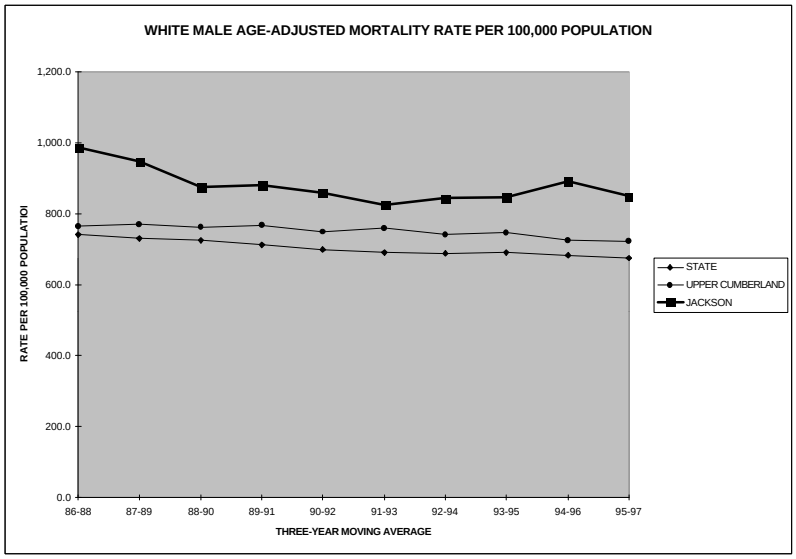



OTHER RACES MALE AGE-ADJUSTED MORTALITY RATE PER 100,000 POPULATION
1,200.0
1,000.0
800.0
600.0
400.0
200.0
0.0
RATE PER 100,000 POPULATIOI
86-88
87-89
88-90
89-91
90-92
91-93
92-94
93-95
94-96
95-97
THREE-YEAR MOVING AVERAGE
STATE
UPPER CUMBERLAND
JACKSON


FEMALE BREAST CANCER MORTALITY RATE PER 100,000 WOMEN AGES 40 YEARS AND OLDER
160
140
120
100
80
60
40
20
0
RATE PER 100,000 POPULATIOI
85-87
86-88
87-89
88-90
89-91
90-92
91-93
92-94
93-95
94-96
THREE-YEAR MOVING AVERAGE
STATE
UPPER CUMBERLAND
JACKSON

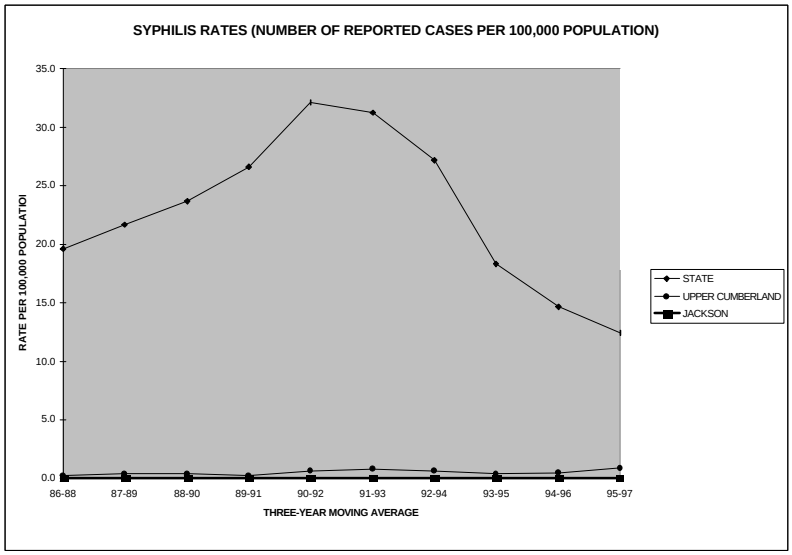

WHITE FEMALE AGE-ADJUSTED MORTALITY RATE PER 100,000 POPULATION
600.0
500.0
400.0
300.0
200.0
100.0
0.0
RATE PER 100,000 POPULATIOI
86-88
87-89
88-90
89-91
90-92
91-93
92-94
93-95
94-96
95-97
THREE-YEAR MOVING AVERAGE
STATE
UPPER CUMBERLAND
JACKSON

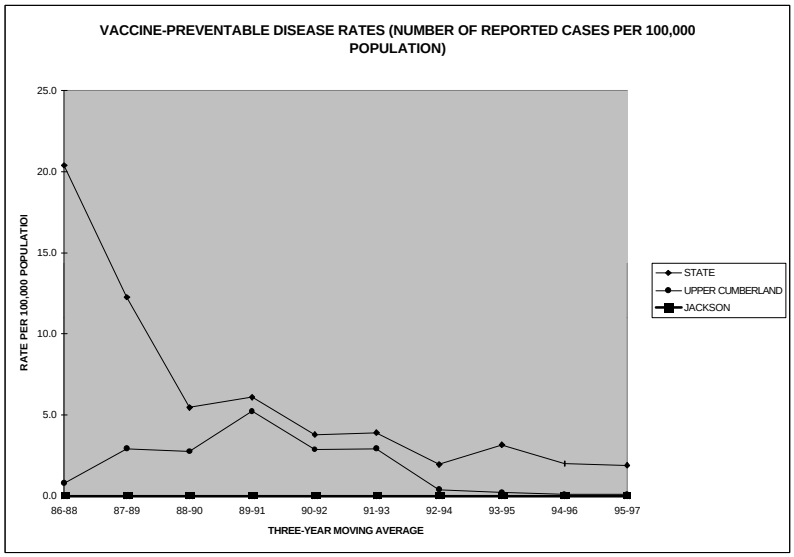

MOTOR VEHICLE ACCIDENTAL MORTALITY RATE PER 100,000 POPULATION
RATE PER 100,000 POPULATIOI
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
86-88
87-89
88-90
89-91
90-92
91-93
92-94
93-95
94-96
95-97
THREE-YEAR MOVING AVERAGE
STATE
UPPER CUMBERLAND
JACKSON

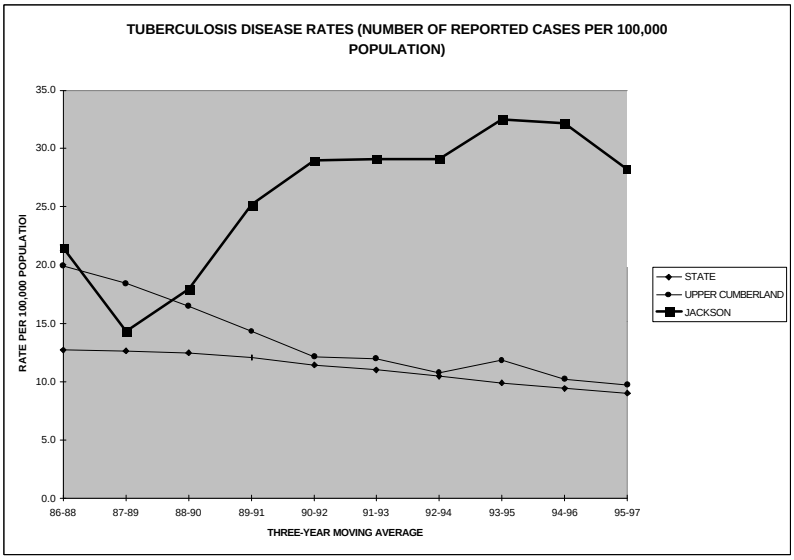

WHITE MALE AGE-ADJUSTED MORTALITY RATE PER 100,000 POPULATION
RATE PER 100,000 POPULATIOI
1,200.0
1,000.0
800.0
600.0
400.0
200.0
0.0
86-88
87-89
88-90
89-91
90-92
91-93
92-94
93-95
94-96
95-97
THREE-YEAR MOVING AVERAGE
STATE
UPPER CUMBERLAND
JACKSON

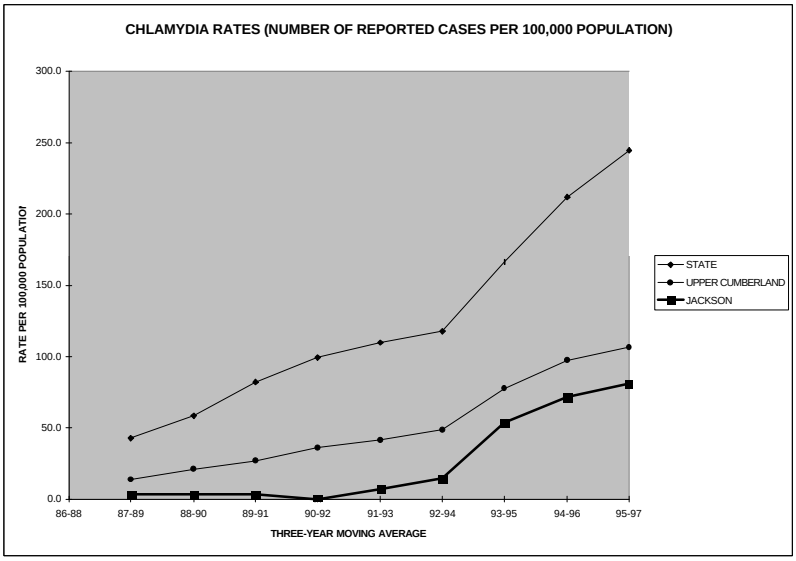
Appendix 5

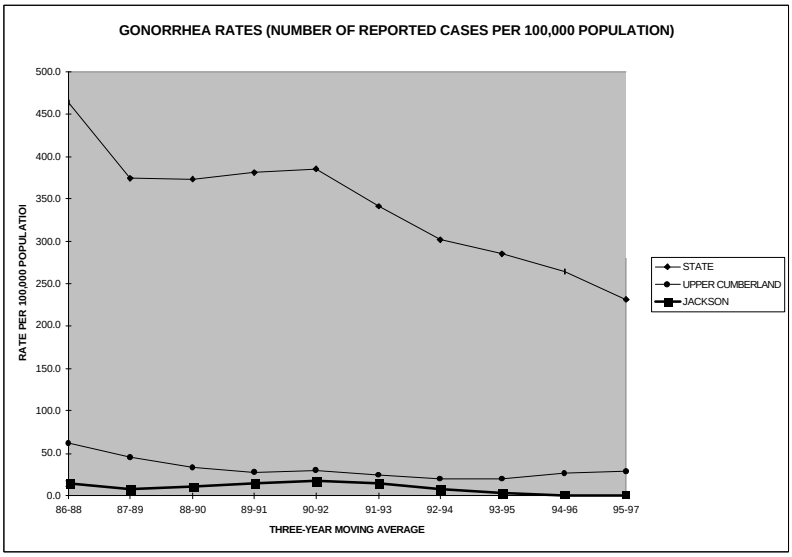
Morbidity Data






TUBERCULOSIS DISEASE RATES (NUMBER OF REPORTED CASES PER 100,000 POPULATION)
RATE PER 100,000 POPULATIOI
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
86-88
87-89
88-90
89-91
90-92
91-93
92-94
93-95
94-96
95-97
THREE-YEAR MOVING AVERAGE
STATE
UPPER CUMBERLAND
JACKSON


CHLAMYDIA RATES (NUMBER OF REPORTED CASES PER 100,000 POPULATION)
RATE PER 100,000 POPULATIOI
300.0
250.0
200.0
150.0
100.0
50.0
0.0
86-88
87-89
88-90
89-91
90-92
91-93
92-94
93-95
94-96
95-97
THREE-YEAR MOVING AVERAGE
STATE
UPPER CUMBERLAND
JACKSON


GONORRHEA RATES (NUMBER OF REPORTED CASES PER 100,000 POPULATION)
RATE PER 100,000 POPULATIOI
500.0
450.0
400.0
350.0
300.0
250.0
200.0
150.0
100.0
50.0
0.0
86-88
87-89
88-90
89-91
90-92
91-93
92-94
93-95
94-96
95-97
THREE-YEAR MOVING AVERAGE
STATE
UPPER CUMBERLAND
JACKSON

Appendix 6

Alcohol and Drug Task Force

Kevin King
Safe and Drug Free Schools Coordinator

Steven Lee
Minister

Margie Quarels
Concerned Citizen/Business Owner

Marilyn Dibble
Concerned Citizen/Retired Nurse

Kim Kompel
Health Educator

Lou Ann Grossberg
Community Development Coordinator

Appendix 7

Verbiage & Internet Address of HIT

Health Information Tennessee Web page created as a partnership between the TN Department of Health and the UTK Community Health Research Group can be located at:

server.to/hit